Supreme Court, U.S.
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No.

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Petitioner,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a provision (42 U.S.C. § 1395ww(h)(2)(A)) in 1986 legislation establishing a new Medicare payment methodology for graduate medical education ("GME") costs, which directs the Secretary of Health and Human Services ("the Secretary") to "determine," for a hospital's 1984 cost reporting year, "the average amount [of the hospital's GME costs] recognized as reasonable under this subchapter . . . for each full-time-equivalent resident," requires the Secretary to "determine . . . the average" using the actual, final "amount recognized as reasonable under this subchapter" for 1984 or whether it authorizes the Secretary, in determining the average, to reaudit and redetermine the amount of 1984 GME costs after the reopening and record-retention periods for 1984 have expired.

PARTIES TO THE PROCEEDINGS

Petitioner is St. Paul-Ramsey Medical Center, Inc., a not-for-profit teaching hospital located in St. Paul, Minnesota. Petitioner does not have a parent or any non-wholly owned subsidiaries.

Respondent is Donna E. Shalala, Secretary of the Department of Health and Human Services.

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Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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PETITION FOR A WRIT OF CERTIORARI

St. Paul-Ramsey Medical Center, Inc. respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (Appendix ("App.") at 1a-3a) is reported at 91 F.3d 57. The opinion of the district court (App. at 4a-8a) is unreported.

JURISDICTION

The court of appeals entered its judgment on July 26, 1996. App. at 1a. It denied petitioner's petition for rehearing on September 30, 1996. App. at 9a. Justice Thomas granted two extensions of time for filing a writ of certiorari in this case, the second of which (entered

January 9, 1997) extended the time to and including February 27, 1997. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1395ww(h)(2)(A) provides: "The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." So that the Court may review the provision in context, substantial portions of 42 U.S.C. § 1395ww(h) are reproduced in the appendix at 10a-15a. In addition, relevant portions of the following are reproduced in the appendix at 15a-19a: 42 U.S.C. § 1395oo; 42 U.S.C. § 1395ww(a)(1)(C); 42 U.S.C. § 1395ww(b)(3)(A); 42 C.F.R. § 405.481(g) (1995); 42 C.F.R. § 405.1803(a); 42 C.F.R. § 405.1807; 42 C.F.R. § 405.1885(a); and 42 C.F.R. § 413.86(e)(1).

STATEMENT

At issue in this case is the proper construction of a provision in 1986 legislation establishing a new Medicare payment methodology for graduate medical education ("GME") costs effective for cost reporting years beginning on or after July 1, 1985. Medicare had previously reimbursed teaching hospitals the "reasonable costs" of GME services. Under the new methodology, each year Medicare reimburses teaching hospitals a percentage, based on the ratio of Medicare patient days to total patient days, of a base year (1984) amount per intern and resident (updated for inflation) times the hospital's number of interns and residents during the payment year. With respect to the base year per resident amount, the statute directs the Secretary to "determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident."

The Secretary waited until September 29, 1989, three and a half years after the statute's enactment, to issue regulations. By that date, hospitals had long since received determinations of the costs recognized as reasonable for 1984 and had received payment based on those determinations. Many of these determinations (including the determination issued to petitioner) were final and no longer subject to reopening, and teaching hospitals were no longer even required to retain audit documentation for 1984. Nonetheless, the Secretary issued a regulation, commonly referred to as the "reaudit regulation," requiring reaudits of GME costs for closed base years for purposes of determining the average base year per resident amount.

Petitioner challenges the validity of the reaudit regulation. Petitioner contends that in computing "the average" required by the 1986 legislation, the Secretary must use as the numerator the actual "amount [of GME costs] recognized as reasonable" *for* 1984, not a fictitious amount divorced from the actual amount recognized as reasonable and paid to the hospital for 1984.

A. Medicare Reasonable Cost Reimbursement

In 1965, Congress enacted the Medicare program primarily to furnish health insurance for the elderly. Pub. L. No. 89-97, § 102(a). From that time until 1983, the Medicare program reimbursed participating hospitals the "reasonable cost" incurred in furnishing services to Medicare patients. *Good Samaritan Hospital v. Shalala*, 113 S. Ct. 2151, 2154 (1993).[1]

Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective

[1] The only exception was if a hospital's costs exceeded its prevailing charges, in which case it was reimbursed its charges. 42 U.S.C. § 1395f(b)(1).

payment system ("PPS") to reimburse most hospitals for inpatient *operating* costs. Pub. L. No. 98-21, § 601(e), enacting 42 U.S.C. § 1395ww(d). Congress retained the "reasonable cost" reimbursement system for certain hospital costs, including the costs of medical education. 42 U.S.C. § 1395ww(a)(4).

B. The Medicare Audit And Review Process

The Secretary has contracted Medicare audit and payment functions to organizations (usually insurance companies) known as fiscal intermediaries. 42 U.S.C. § 1395h; *Bethesda Hospital Association v. Bowen*, 485 U.S. 399, 400-01 (1988). At the close of a year, a hospital participating in the Medicare program, commonly referred to as a "provider," files a cost report with its Medicare intermediary, which audits the cost report and issues a determination of the costs recognized as reasonable in a notice of program reimbursement ("NPR"). 42 U.S.C. § 1395oo(a)(1)(A)(i); 42 C.F.R. § 405.1803 (a)(1); *Bethesda Hospital Association*, 485 U.S. at 401. A provider dissatisfied with the intermediary's determination may appeal to the Provider Reimbursement Review Board ("PRRB" or "Board") and eventually file a court suit. 42 U.S.C. § 1395oo(f)(1).

The intermediary's "findings on matters at issue" in the NPR are subject to reopening for a period of three years. 42 C.F.R. § 405.1885(a). Except in cases of fraud, no intermediary determination "may be reopened after such 3-year period." *Id.* If the provider does not appeal and a reopening has not been effected within the three-year period, the intermediary's determination is "final and binding." 42 C.F.R. § 405.1807.

C. The GME Per Resident Amount Payment Methodology

In 1985, the Secretary issued a regulation which purported to freeze medical education payments for one year at 1984 levels. Under the Secretary's regulation, a hospital's medical education reimbursement for its first cost reporting year beginning on or after July 1, 1985, would have been the lower of its allowable medical education costs for that year or for its cost reporting year beginning in fiscal year 1984 (the base year). 42 C.F.R. § 405.421 (a)(2)(i) (1985); 50 Fed. Reg. 27,732 (1985). In the accompanying preamble, the Secretary made clear that the final determination of allowable base year costs for the base year itself would also be used for purposes of the freeze. 50 Fed. Reg. 27,726 (1985).

In April 1986, Congress repealed the Secretary's freeze, and adopted a new GME payment methodology (effective for cost reporting years beginning on or after July 1, 1985), based, like the Secretary's regulation, on a hospital's GME costs during fiscal year 1984. Pub. L. No. 99-272, § 9202. The statute directed the Secretary to calculate an "average" for each hospital. 42 U.S.C. § 1395ww(h)(2)(A). This was to be done by dividing the hospital's GME costs "recognized as reasonable under this subchapter" for 1984 by the hospital's number of interns and residents in 1984, to yield "the average" base year amount per resident. *Id.* For a year subject to the new methodology, Medicare pays a percentage, based on Medicare patient days to total patient days, of the base year per resident amount adjusted for inflation times the hospital's number of residents during the year.[2] 42 U.S.C. § 1395ww(h).

D. The Reaudit Regulation

On September 29, 1989, the Secretary issued regulations to implement the GME statute. 54 Fed. Reg. 40,286-321, adopting 42 C.F.R. § 413.86. By that date,

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[2] For instance, if in 1996 a hospital's adjusted base year per resident amount was $60,000, its number of residents was 10, and its Medicare patient load (*i.e.*, Medicare patient days to total patient days) was 25%, the hospital's Medicare GME payment would be $150,000 ($60,000 x 10 x 25%).

the Medicare intermediaries had long since audited, and issued NPRs for, the 1984 year which is the base year under the new GME payment system. In many cases, the NPR for 1984 had been issued more than three years earlier so that the amount of GME costs recognized as reasonable in the NPR for 1984 was final, binding, and no longer subject to reopening. *See* 42 C.F.R. § 405.1885 (a). In addition, by that date hospitals were no longer required to retain the time records necessary for an audit of 1984 GME costs. 42 C.F.R. § 405.481(g)(3) (1995).

Nonetheless, the Secretary did not instruct the intermediaries to use the 1984 GME costs already recognized as reasonable in the normal audit and review process to determine the "average" GME per resident amount. Instead, the Secretary issued the reaudit regulation, which directed the intermediaries to reaudit a hospital's 1984 year to redetermine the 1984 GME costs to be used for the GME per resident amount calculation. 42 C.F.R. § 413.86(e)(1)(ii)-(iii). The Secretary asserted that a reaudit of 1984 costs was necessary to ensure the accuracy of the per resident amount. 54 Fed. Reg. 40,300 (1989).

As a practical matter, a reaudit of 1984 costs often proved to be impossible. Under the Secretary's record-retention requirements (42 C.F.R. § 405.481(g)(3) (1995)), hospitals were required to retain physician allocation agreements and time records for a period of only four years after the close of a cost reporting year.[8] The four-year record retention period had already expired when the Secretary issued the reaudit regulation, and

[8] Physician compensation attributable to teaching activities is a major component of a hospital's GME costs. 42 C.F.R. § 413.85(g). Hospitals conducted time studies to establish the percentage of a physician's compensation attributable to various activities, including teaching and supervision of interns and residents in approved GME programs. 42 C.F.R. § 405.481(g) (1995), *removed*, 60 Fed. Reg. 63,124, 63,175 (1995).

many hospitals no longer had the necessary records, a fact ultimately acknowledged by the Secretary in a *Federal Register* notice. 55 Fed. Reg. 36,063-64 (1990).

E. Intermediary's Reaudit Of Petitioner's 1984 GME Costs

Petitioner is a not-for-profit teaching hospital located in St. Paul, Minnesota. Petitioner's GME base year is its cost reporting year ending December 31, 1984. R. 1, Complaint at 12, ¶ 35; R. 4, Answer at 4, ¶ 35. After a full audit, the Medicare intermediary issued the NPR for petitioner's 1984 fiscal year on February 28, 1986. *Id.*

Three years passed after issuance of petitioner's NPR for 1984 without a reopening related to medical education costs. R. 1, Complaint at 12, ¶ 36; R. 4, Answer at 4, ¶ 36. Accordingly, as of March 1, 1989 (three years and one day after issuance of the NPR), the intermediary's determination was "final and binding" and no longer subject to reopening. 42 C.F.R. §§ 405.1807, 405.1885 (a). Moreover, as of January 1, 1989 (four years and one day after the close of its GME base year), petitioner was no longer even required to retain the physician allocation documentation supporting the GME costs recognized as reasonable in the NPR for 1984. *See* 42 C.F.R. § 405.481(g)(1), (3) (1995); R. 1, Complaint at 13, ¶ 37; R. 4, Answer at 4, ¶ 37.

The Medicare intermediary nonetheless began reauditing petitioner's 1984 year in late 1990 for purposes of the GME per resident amount methodology. R. 1, Complaint at 13, ¶ 38; R. 4, Answer at 4, ¶ 38. On February 18, 1991, the intermediary issued a notice of average per resident amount for petitioner's 1984 year. *Id.* The intermediary computed the per resident amount in that notice by using as the numerator a "reaudited" amount of 1984 GME costs which is lower than the amount recognized as reasonable in the NPR for 1984. *Id.* The Medicare intermediary has used this per resident amount—based

on the *1991* reaudit determination of 1984 GME costs, rather than the determination in the NPR for 1984—to reimburse petitioner under the per resident methodology for all cost reporting years beginning on or after July 1, 1985. The intermediary has not applied the reaudited 1984 GME cost determination directly to petitioner's 1984 year, and petitioner's GME reimbursement for that year (which was based on the NPR) remains unchanged. R. 1, Complaint at 13-14, ¶ 39; R. 4, Answer at 4, ¶ 39.

Petitioner timely appealed the intermediary's notice of average per resident amount to the PRRB. R. 1, Complaint at 14, ¶ 40; R. 4, Answer at 4, ¶ 40. Petitioner challenged the legality of the Secretary's reaudit regulation, contending that the Secretary must use the amount of GME costs actually recognized as reasonable for 1984 through the normal audit and review process (rather than the reaudit amount) to determine the average base year per resident amount under the new methodology.

The PRRB ruled that it lacks the authority to decide the validity of the reaudit regulation, thereby allowing petitioner to file a court suit challenging the validity of the regulation.[4] R. 1, Complaint at 14-15, ¶ 41; R. 4, Answer at 4, ¶ 41. Petitioner timely filed suit in the U.S. District Court for the District of Minnesota within the period allowed by the Medicare statute. R. 1, Complaint at 15, ¶ 42; R. 4, Answer at 4, ¶ 42.

F. Court Decisions

On August 8, 1995, the district court issued a short opinion upholding the validity of the reaudit regulation.

[4] The PRRB lacks the authorty to invalidate a Medicare regulation. It is legally required to comply with all of the Secretary's Medicare regulations. 42 C.F.R. § 405.1867; *Bethesda Hospital Association*, 485 U.S. at 406. Accordingly, the Medicare statute establishes a procedure under which providers may seek judicial review of any question which the PRRB determines it lacks the authority to decide. 42 U.S.C. § 1395oo(f)(1); R. 1, Complaint at 7-8, ¶¶ 21-23; R. 4, Answer at 3, ¶¶ 21-23.

App. at 4a-8a. The court relied on the reasoning in *Administrators of the Tulane Educational Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994) ["*Tulane*"], and *The Toledo Hospital v. Shalala*, No. 3:94CV7080 (N.D. Oh. 1995), a decision that recently has been reversed by the U.S. Court of Appeals for the Sixth Circuit. *Id.* at 7a-8a.

On July 26, 1996, the U.S. Court of Appeals for the Eighth Circuit affirmed in a brief *per curiam* opinion. App. at 1a-3a. The court concluded that the reaudit regulation "must be upheld for the reasons persuasively stated by the D.C. Circuit in *Tulane*." *Id.* at 3a. The court noted that "it would have been far preferable had the Secretary promulgated the reaudit regulations during the three-year reopening period governing 1984 reimbursements. . . ." *Id.* However, the court concluded that the statute is "ambiguous" and that the Secretary's regulation represents a reasonable measure to ensure the accuracy of per resident amounts. *Id.*

REASONS FOR GRANTING THE PETITION

I. THE COURT OF APPEALS' CONSTRUCTION OF 42 U.S.C. § 1395ww(h)(2)(A) CONFLICTS WITH THE SIXTH CIRCUIT'S CONSTRUCTION.

The D.C. Circuit in *Tulane* and the Eighth Circuit in this case upheld the validity of the Secretary's reaudit regulation, finding the regulation consistent with 42 U.S.C. § 1395ww(h)(2)(A). More recently, however, the Sixth Circuit has reached a contrary conclusion in *The Toledo Hospital v. Shalala*, No. 95-3858 (Jan. 13, 1997), App. at 20a-37a. The Sixth Circuit invalidated the Secretary's reaudit regulation, concluding that the regulation conflicts with 42 U.S.C. § 1395ww(h)(2)(A). Thus, there is a direct conflict between the decision in this case and the decision of the Sixth Circuit in *Toledo*. More specifi-

cally, as addressed below, there is a direct conflict between the two decisions on three fundamental points: (1) the proper application of the principles of construction established in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984); (2) whether 42 U.S.C. § 1395ww(h)(2)(A) is ambiguous; and (3) assuming that 42 U.S.C. § 1395ww(h)(2)(A) is ambiguous, whether the reaudit regulation represents a reasonable construction of the statute.

A. All three courts agreed that the validity of the reaudit regulation should be assessed under the familiar two-step analysis in *Chevron*.[6] However, the courts had significantly different understandings of *Chevron*. In *Tulane* (whose reasoning was adopted by the Eighth Circuit), the D.C. Circuit found ambiguity because the statute does not expressly address and prohibit a reaudit after the expiration of reopening and record-retention periods. In *Toledo*, the Sixth Circuit rejected this approach to *Chevron* deference, stating:

> With due respect to our sister courts, we believe that the approach taken by the court in *Tulane* misperceives the policy underlying *Chevron* deference. *Chevron* instructs courts to accept a reasonable administrative interpretation of a statute where Congress has delegated decisional autonomy to an agency. When Congress intentionally leaves gaps and ambiguous terms in a statute for the agency to flesh out, the principle of separation of powers counsels that this legislative delegation be respected by the judiciary. It is an entirely different matter, however, to presume a delegation of interstitial rulemaking authority when the claimed ambiguity in the statute stems not from the use of a word with several plausible interpretations, nor from the statute's lack of

[6] The relevant question under the first step is whether Congress' intent is clear. 467 U.S. at 842-43. If so, Congress' intent must prevail. If not, the relevant question under the second step is whether the agency's construction is reasonable. *Id.* at 843.

> specificity regarding mundane procedural issues, but from nothing more than the failure of Congress to proscribe explicitly an unusual procedure which may be plainly at odds with the result Congress was trying to reach.

App. at 29a. The Sixth Circuit concluded that "under *Chevron* analysis, a regulation does not survive the first step merely because there is a metaphysical possibility that the statute could be read in the manner advocated by the agency." *Id.* at 34a.

B. The Sixth Circuit also disagreed that 42 U.S.C. § 1395ww(h)(2)(A) is ambiguous. App. at 29a-34a. It faulted the District of Columbia and the Eighth Circuits for failing to give proper consideration to the word "average," a word which the Sixth Circuit viewed as "critical to understanding congressional intent." *Id.* at 29a-30a. Congress was undoubtedly aware of the normal administrative process for establishing final payment determinations and the normal three year reopening period, which was not even close to expiring for 1984 cost reporting years when the GME statute was enacted. *Id.* at 30a-31a. Thus, reasoned the Sixth Circuit, Congress must have expected the Secretary to use the costs determined through the normal administrative process to calculate the "average" GME costs per resident for 1984. *Id.* In the court's view, the GME statute is "not at all complex" but "merely directs the Secretary to divide one number by another." *Id.* at 31a-32a. Nothing in the statute authorizes the Secretary to redetermine the numerator used to compute the "average." *Id.* at 32a-33a.

The court found additional support for its conclusion in the traditional presumption of issue preclusion. *Id.* at 33a. Absent a contrary expression of congressional intent, parties should not be required to "reestablish or relitigate factual matters that have already been determined with finality." *Id.* It was clear to the court that

the Secretary had "strayed from the path intended by Congress" and that the reaudit regulation therefore flunks *Chevron* Step One. *Id.* at 34a.

C. Even assuming arguendo an ambiguity in the statute, the Sixth Circuit also disagreed with the District of Columbia and Eighth Circuits that the Secretary's construction could survive scrutiny under *Chevron* Step Two. *Id.* at 34a-37a. The Sixth Circuit rejected the Secretary's claim that a reaudit was necessary to ensure accuracy in the per resident amounts. The court found that the reaudit regulation was unreasonable and unfair because (1) Congress expected the cost determinations made directly for 1984 to be right, (2) providers should not be required to "reestablish the costs that they already proved years ago," particularly at a time when they were no longer required to retain supporting audit documentation, and (3) the alleged need to audit closed years, if it existed at all, arose solely because of the Secretary's inexcusable dilatoriness. *Id.* In the court's view, the "predicament was of the Secretary's making and it is unreasonable to expect the Hospital to answer for it." *Id.* at 37a.

II. THE DECISION OF THE COURT OF APPEALS IS ERRONEOUS.

A. The Secretary's Reaudit Regulation Violates the Plain Meaning And Clear Intent Of 42 U.S.C. § 1395ww(h)(2)(A).

1. The statute directs the Secretary to determine an "average." She does this by dividing (A) the "amount recognized as reasonable under this subchapter" for a hospital's 1984 cost reporting year by (B) the hospital's number of full-time-equivalent residents for that period.

The meaning of the words "amount recognized as reasonable under this subchapter" is clear. The referenced "subchapter" is subchapter XVIII of the Social Security Act, which "subchapter" is often referred to as the Medicare statute. Subchapter XVIII contains a long-established process for determining the amount of Medicare payment recognized as reasonable for *each* hospital for *each* year. *See Bethesda Hospital Association*, 485 U.S. 399 (1988); *Hospital Association of Rhode Island v. Secretary of HHS*, 820 F.2d 533 (1st Cir. 1987); *HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 615 (D.C. Cir. 1994). It directs the Medicare intermediary to make a "final determination" as to each hospital's payment entitlement for each cost reporting year. 42 U.S.C. § 1395oo(a). A hospital dissatisfied with this determination has 180 days to appeal to the PRRB. 42 U.S.C. § 1395oo(f)(1). The intermediary may reopen the determination within a three-year period. 42 C.F.R. § 405.1885(a). Once that period expires, the determination is "final and binding." 42 C.F.R. § 405.1807. Thus, the statutory phrase "amount recognized as reasonable under this subchapter" for 1984 clearly refers to the amount established in the NPR upon completion of the normal audit and review process.

The *Tulane* court focused on the word "determine," suggesting that "determine" is an "activist" word that is reasonably construed as authorizing the Secretary to conduct a special reaudit of 1984 GME costs. 987 F.2d at 796 n.6. But for purposes of establishing an "average," "determine" is no more "activist" than "compute" or "calculate." *Directing the Secretary to "determine" an "average" by dividing (A) by (B) does not authorize the Secretary to "redetermine" (A).*

As part of the base year audit, the Secretary determined the amount of GME costs "recognized as reasonable." However, she did not, in the base year audit, determine the number of residents, nor did she determine the *average* amount "recognized as reasonable" *per resident*. Thus, to implement the new payment methodology, the Secretary needed to determine the number of residents and do a mathematical calculation not done for

the base year audit, *i.e.*, divide the GME costs "recognized as reasonable" in the base year audit by the number of interns and residents to produce the *average* base year per resident amount. But the determination of this "average" in no way required, or allowed, the Secretary to "redetermine" the numerator. As the Sixth Circuit correctly observed, Congress' sole directive in 42 U.S.C. § 1395ww(h)(2)(A) was for the Secretary to "determine . . . the average." App. at 29a-33a. Thus, the reaudit regulation does what the Secretary lacks the authority to do.

2. Throughout the GME legislation, Congress was careful to confer express authority on the Secretary where rulemaking was required. For instance, the number of a hospital's interns and residents (the denominator in the per resident amount formula) had no bearing on GME reimbursement for 1984, and the Secretary did not have a methodology for establishing the number for purposes of GME payment. Accordingly, Congress expressly authorized the Secretary to establish rules "for the computation of the number of full-time-equivalent residents in an approved medical residency training program" and furnished copious guidance. 42 U.S.C. § 1395ww(h)(4).

No such authorization will be found with respect to the numerator. The Medicare statute and regulations long ago established the process by which the Secretary determines the amount of GME costs recognized as reasonable for each cost reporting year. If Congress had intended for the Secretary to bypass that process and create a new process, it surely would have said so. *See Director, Office of Workers' Compensation Programs v. Newport News Shipbuilding and Dry Dock Co.*, 115 S. Ct. 1278, 1288 (1995) ("The withholding of agency authority is as significant as the granting of it, and we have no right to play favorities between the two"). Congress did not do so.

3. Both the *Toledo* court and the *Tulane* district court correctly noted that had Congress intended the Secretary's

construction, it would have worded the statute quite differently. *Toledo*, App. at 33a-34a; *Methodist Hospitals of Memphis v. Sullivan*, 799 F. Supp. 1210, 1218 (D.D.C. 1992). If the Secretary's construction were correct, the statute would say something like this:

> The Secretary shall redetermine, for purposes of this section, the amount of the hospital's allowable direct graduate medical education costs for the hospital's cost reporting period that began during fiscal year 1984, and, based on that redetermined amount, the Secretary shall determine the hospital's average amount of allowable direct graduate medical education costs for each full-time-equivalent resident for such year.

Instead, the statute directs the Secretary to use as the numerator the "amount" of a hospital's GME costs "recognized as reasonable under this subchapter" for 1984. A greater disparity between the language that Congress should have used if it had intended the Secretary's construction and the actual language employed is hard to imagine

4. The Secretary's reading of the statutory language is inconsistent with her own, and the courts', treatment of identical language in the Medicare statute. The phrase "costs . . . recognized . . . under this subchapter" appears in other statutory provisions that use base year cost data to determine Medicare reimbursements. *See* 42 U.S.C. §§ 1395ww(a)(1)(C) and 1395ww(b)(3)(A)(i). In these contexts, the Secretary has consistently "recognized" those base year costs that have been adopted as part of a final cost determination under 42 C.F.R. § 405.1807. In the one instance when the Secretary attempted to disturb final base year cost determinations, the courts blocked this effort as contrary to the statute. *Georgetown Univ. Hosp. v. Bowen*, 862 F.2d 323, 327 (D.C. Cir. 1988). The Secretary's construction of 42 U.S.C. § 1395ww(h)(2)(A) thus conflicts with the "normal

rule of statutory construction that identical words used in different parts of the same act are intended to have the same meaning." *Sullivan v. Stroop*, 496 U.S. 478, 484 (1990) (construing other chapters of the Social Security Act) (internal quotations omitted).

B. Even Assuming Arguendo An Ambiguity In The Statutory Language, The Reaudit Regulation Adopts A Patently Unreasonable Construction.

1. The *Tulane* court held that the reaudit regulation is reasonable because of the importance of ensuring the accuracy of the base year amount. This rationale does not bear analysis. The original determinations were *audited* figures. The original audits were performed shortly after the 1984 year, when audit documentation was still readily available, when memories were still fresh, and when hospital and intermediary personnel had not substantially turned over. There is no evidence of inaccuracy in those determinations. The *Tulane* court simply accepted on faith the Secretary's conclusory allegations that the 1991 reaudits were likely to be more accurate than the 1986 audits.

But even more fundamentally, a "plain meaning" construction of the statute would not have prevented the Secretary from correcting any errors that might have existed. When the GME statute was enacted, the amount recognized as reasonable for 1984 was still subject to reopening. Thus, as the *Tulane* district court correctly observed, "[a]ny concern the Secretary might have had about the accuracy of those figures could have been addressed within the standard three-year period time." *Methodist Hospitals of Memphis*, 799 F. Supp. at 1218.

2. The Medicare reopening standards apply "with respect to findings on matters at issue" in a determination. 42 C.F.R. § 405.1885(a). The "matters at issue" for which intermediaries made "findings" in the NPRs issued for 1984 in early 1986 were the allowability of a hospital's

1984 GME costs. Those were also the "matters at issue" for which intermediaries made new "findings" in the 1991 reaudits. Since those new "findings" of 1984 costs were made after the three-year reopening period had expired, they obviously conflicted with the Secretary's reopening standards. It matters not whether the Secretary applied those "findings" of 1984 costs directly to a hospital's 1984 year or to the hospital's 1990 year under the per resident amount methodology.

The reaudit regulation also conflicts with principles of res judicata and collateral estoppel. When an issue has been resolved for one year, principles of res judicata and collateral estoppel make that decision binding for subsequent years involving the same issue. *Tait v. Western Maryland Railway Co.*, 289 U.S. 620 (1933); *United States v. Moser*, 266 U.S. 236 (1924). Res judicata and collateral estoppel apply to final administrative determinations so long as there was "an adequate opportunity to litigate" the issue in the original determination, as there clearly was here. *United States v. Utah Construction & Mining Co.*, 384 U.S. 394, 422 (1966); *Draper v. Sullivan*, 899 F.2d 1127, 1130-31 (11th Cir. 1990). It is irrational to assume that Congress intended the Secretary to retroactively revoke her own reopening standards and ignore settled principles of res judicata and collateral estoppel. Only the clearest and most direct statutory command could possibly justify such a result.

3. Rationalizing the reaudits as necessary to ensure accuracy fails to take into account the purposes of a statute of limitations, of which the Medicare reopening standards are the functional equivalent. *See Pellham Bay General Hospital v. Schweiker*, [1984-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 33,468 at 9360 & n.9 (D.D.C. 1983). In *Board of Regents of the University of the State of New York v. Tomanio*, 446 U.S. 478, 487 (1980), this Court described those purposes as follows:

> Statutes of limitations are not simply technicalities. . . . [T]here comes a point at which the delay of a plaintiff in asserting a claim is sufficiently likely either to impair the accuracy of the fact-finding process or to upset settled expectations that a substantive claim will be barred without respect to whether it is meritorious.

Elsewhere, the Court has stated:

> Statutes of limitations, which are "found and approved in all systems of enlightened jurisprudence," represent a pervasive legislative judgment that it is unjust to fail to put the adversary on notice to defend within a specified period of time and that "the right to be free of stale claims in time comes to prevail over the right to prosecute them." These enactments are statutes of repose; . . . they protect defendants and the courts from having to deal with cases in which the search for truth may be seriously impaired by the loss of evidence, whether by death or disappearance of witnesses, fading memories, disappearance of documents, or otherwise.

United States v. Kubrick, 444 U.S. 111, 117 (1979) (citations omitted).

The Medicare reopening standards were intended to ensure, not impede, accuracy. The reaudit regulation allows exactly what the reopening standards were designed to prevent—the impairment of the "accuracy of the fact-finding process" and the "unjust" treatment of hospitals that had already been put on notice that the determination of 1984 costs was "final and binding." It defies belief that a 1991 audit of a 1984 cost reporting year, conducted two years after that year was closed under long-established Medicare principles, will yield more accurate results than did the 1986 audit of the 1984 reporting year.

4. When the GME statute was enacted, the amounts recognized as reasonable for 1984 were not final and

remained subject to reopening. Under these circumstances, Congress obviously did not intend that the Secretary make two separate determinations of allowable GME costs under "reasonable cost" principles for the same period of time. An agency may not rationally apply the same principles to the same provider for the same period of time (1984) to reach two equally valid but different determinations of allowable costs. *See Methodist Hospitals of Memphis*, 799 F. Supp. at 1218. If the first determination is final and valid (as the Secretary concedes it is), the later, inconsistent determination must necessarily be invalid. *See, e.g., American Federation of Government Employees, AFL-CIO, Local 3090 v. FLRA*, 777 F.2d 751, 760 (D.C. Cir. 1985) (Scalia, J., concurring) ("I do not think it to be true . . . that an agency is free to take inconsistent positions. . . . It is the agency's responsibility to behave in a rational (and hence reasonably consistent) fashion").

The Secretary's construction is premised on the absurd proposition that Congress intended to allow the Secretary to wait until 1991 (five years after the enactment of the GME statute), when 1984 years were closed and hospitals were no longer required to retain key supporting documentation, to reaudit 1984 costs for purposes of a methodology that applies to hospital cost reporting years beginning in 1985. Nor does the absurdity of the Secretary's position end there. If the Medicare finality rules do not apply, then there are no time constraints on the Secretary. If the Secretary was entitled to reaudit 1984 costs in 1991, nothing prevents her from reauditing 1984 costs again in 1998 or 2001 if she decides that there may have been some problem with the 1991 reaudit. The logic of the Secretary's position would potentially subject hospitals to an endless series of reaudits of 1984 costs.

C. The Secretary's Reaudit Regulation Is Impermissibly Retroactive.

Absent express statutory authority, the Secretary lacks the authority to issue a retroactive rule. *Bowen v. George-*

town University Hospital, 488 U.S. 204 (1988). The Secretary's reaudit regulation is impermissibly retroactive in several respects.

1. The reaudit regulation is obviously retroactive for the period July 1, 1985, through October 30, 1989—a period of almost four and a half years. The Secretary's regulations were issued on September 29, 1989, with an October 30, 1989 effective date. 54 Fed. Reg. 40,286 (1989). However, the Secretary is applying the regulation to all cost reporting periods beginning on or after July 1, 1985.

2. The reaudit regulation imposes a significant new burden with respect to petitioner's 1984 year. It subjects the 1984 cost reporting year to a reaudit that was no longer permissible under the Medicare subchapter.

The Secretary's contention that her construction simply uses antecedent facts for prospective purposes is patently false. The Secretary's construction upsets hospitals' vested rights with respect to "final and binding" determinations applicable to antecedent facts. 42 C.F.R. §§ 405.1807, 405.1885(a). The effect of the reaudit regulation was to retroactively revoke the reopening and record-retention standards applicable to 1984, *after* the reopening and record-retention periods for 1984 had already expired. *Id.*; 42 C.F.R. § 405.481(g)(1) (1995). Consequently, hospitals were forced to reestablish costs that had been proven with finality long ago.

In *Landgraf v. USI Film Products*, 114 S. Ct. 1483, 1505 (1994), this Court stated that, in assessing retroactivity, courts should be guided by "familiar considerations of fair notice, reasonable reliance, and settled expectations. . . ." 114 S. Ct. at 1499. The GME statute does not provide any sort of "notice," fair or otherwise, that 1984 costs would be subject to reaudit after the Medicare reopening period. Indeed, nothing in the statute suggests that hospitals' "reasonable reliance" and "settled expectations" with respect to the finality of the 1984 cost determinations may be upset.

In *Landgraf*, the Court strongly endorsed "the 'uniformly' accepted rule against 'giv[ing] to statutes a retrospective operation, whereby rights previously vested are injuriously affected, unless compelled to do so by language so clear and positive as to leave no room to doubt that such was the intention of the legislature.'" 114 S. Ct. at 1500 (citation omitted). By the date that the Secretary issued the reaudit regulation, petitioner's rights with respect to the finality of the 1984 cost determination had "vested" (*i.e.*, the determination was final and no longer subject to reopening), and those rights were subsequently "injuriously affected" by the Secretary's reaudit. Accordingly, since the GME statute obviously does not include "language so clear and positive as to leave no room to doubt" that Congress intended the Secretary to inflict this retroactive injury to vested finality rights, the reaudit regulation clearly constitutes an impermissible retroactive construction of the statutory language.[6]

3. In issuing the reaudit regulation, the Secretary retroactively revoked core principles underlying the Medicare PPS for operating costs. Ever since their promulgation in 1983, the Secretary's PPS regulations have specified that the hospital-specific rate is "final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983" except in very limited circumstances not encompassed by the GME reaudit. 42 C.F.R. § 405.474(b)(1)(v) (1983), 42 C.F.R. § 412.71(d) (1996). Moreover, the Secretary's regulations also specified that the characterization of costs (*i.e.*, operating or medical education) used to establish the PPS hospital-specific rate must also be used for future years. 42 C.F.R. § 405.477(c)(2) (1983), 42 C.F.R. § 412.113(b) (1987). As part of the reaudit regulation,

[6] Assuming that *Chevron* were applicable, petitioner agrees with the Sixth Circuit's application of *Chevron* in *Toledo*. However, because of the retroactive nature of the reaudit regulation, petitioner contends that *Landgraf*, not *Chevron*, furnishes the correct standard of review in this case.

the Secretary retroactively revoked both the "consistency rule" and the finality of the PPS hospital-specific rate. *See* 42 C.F.R. § 412.113(b)(3); 42 C.F.R. § 413.86(e)(1)(ii)(B)-(C); 42 C.F.R. § 413.86(j).

In so doing, the Secretary candidly acknowledged in the *Federal Register* preamble to the GME regulations: "There is nothing in section 1886(h) of the [Social Security] Act [42 U.S.C. § 1395ww(h)] that addresses the recomputation of HSRs [hospital-specific rates]." 54 Fed. Reg. 40,301 (column 1) (1989). Thus, the Secretary by her own admission does not possess the express grant of statutory authority necessary under *Georgetown* to retroactively amend the PPS hospital-specific rates—an adjustment that is a necessary by-product of the GME reaudit regulation.

III. THE QUESTION PRESENTED IS IMPORTANT.

The question presented is important for several reasons.

A. At issue is the proper construction of a major federal statute of immense importance in all States of the Union and the District of Columbia. The statute directly and substantially affects the proper amount of Medicare reimbursement for the nation's teaching hospitals. It implicates not only the hospitals' financial well-being, but also has a significant bearing on the quality of the graduate medical education that they are able to furnish.

B. This case involves fundamental principles of administrative fairness. As the Sixth Circuit noted, the underlying question is whether courts should, in the absence of Congressional authorization, "permit administrative agencies to require a party to reestablish or relitigate factual matters that have already been determined with finality." App. at 33a. The Sixth Circuit's answer was that the Secretary may not require providers "to reestablish the costs that they already proved years ago." *Id.* at 36a. The Sixth Circuit properly concluded:

> The Secretary ignored the principle of collateral estoppel and the basic fairness issues implicated. Finally, the Secretary ordered the reaudits to occur only after the providers had been permitted to dispose of the records necessary to allow for a meaningful audit.

Id. at 37a. Administrative agencies need to understand that they cannot disavow final and binding agency determinations upon which parties have justifiably long relied.

C. This case involves important issues regarding the proper principles for reviewing agency constructions of federal statutes. Although both the Sixth Circuit and the Eighth Circuit purported to apply *Chevron*, they had very different understandings of the proper role of the Judiciary in applying *Chevron*, thus demonstrating the need for clarification by this Court. Moreover, the Secretary's revocation in 1989 of the reopening and record-retention standards applicable to 1984, *after* the reopening and record-retention periods for 1984 had already expired for many hospitals (including petitioner), raises important issues under the Court's decisions in *Georgetown* and *Landgraf*. For all these reasons, further review is warranted.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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February 1997

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 95-3477

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Plaintiff-Appellant,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Defendant-Appellee.

Appeal from the United States District Court
for the District of Minnesota

Submitted: June 14, 1996

Filed: July 26, 1996

Before LOKEN, ROSS, and HANSEN, Circuit Judges.

PER CURIAM.

Under the Medicare program, a teaching hospital's graduate education ("GME") costs are reimbursable or "allowable" costs. A 1986 statute changed the reimbursement methodology. To establish a base year for the new methodology, Congress directed the Secretary of Health and Human Services to "determine, for the hosptial's cost reporting period that began during fiscal year 1984, the

average amount recognized as reasonable under this subchapter . . . for each full-time-equivalent resident." 42 U.S.C. § 1395ww(h)(2)(A). By the time the Secretary promulgated regulations implementing this directive in 1989, the three-year reopening period for finally determining 1984 GME costs under the prior regime had expired for most hospitals. The Secretary's regulations nonetheless authorize reauditing a hospital's 1984 base year GME costs so as to exclude "nonallowable or misclassified costs." 42 C.F.R. § 413.86(e)(l)(ii)(B); *see* 53 Fed. Reg. 36,589, 36,591-92 (1988).

As a result of this reaudit process, St. Paul-Ramsey Medical Center's base-year allowable GME costs were reduced from $9,892,644 to $5,494,955. Because the 1984 reimbursement year is closed, St. Paul-Ramsey need not refund any 1984 reimbursements because of this reaudit. But St. Paul-Ramsey has been and will be adversely affected in subsequent years as a result of having its base year GME costs significantly reduced for purposes of applying the new reimbursement methodology. Therefore, like other adversely affected teaching hospitals around the country, St. Paul-Ramsey commenced this lawsuit, arguing not that *its* reaudit was flawed, but that the Secretary's reaudit regulations are invalid. The attack proceeds on three fronts—the regulations contravene the plain meaning of the statutory phrase, "recognized as reasonable under this subchapter"; alternatively, if the statute is ambiguous, the Secretary's interpretation is "patently unreasonable"; finally, the regulations violate the presumption against retroactivity.

These contentions were thoroughly considered and rejected by the District of Columbia Circuit in *Administrators of Tulane Educ. Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 114 S. Ct. 740 (1994). *Accord The Toledo Hosp. v. Shalala*, No. 3:94cv7080 (N.D. Ohio June 23, 1995), *appeal pending*, No. 95-3858 (6th Cir.). After carefully considering the parties'

briefs and arguments and the legislative history of these complex statutes and regulations, we agree with the district court [1] that the Secretary's reaudit regulations must be upheld for the reasons persuasively stated by the D.C. Circuit in *Tulane*. The statute is ambiguous, and the reaudit regulations are not an exercise in retroactive rulemaking. While it would have been far preferable had the Secretary promulgated the reaudit regulations during the three-year reopening period governing 1984 reimbursements, the substance of the regulations is clearly reasonable. As the court said in *Tulane*, 987 F.2d at 797, "The agency's belief that Congress would resist permanently ingraining misclassified and nonallowable costs in future reimbursements to health care providers can hardly be deemed unreasonable or inconsistent with the congressional purpose of erecting a new and more accurate reimbursement methodology."

The judgment of the district court is affirmed.

A true copy.

Attest:

Clerk, U.S. Court of Appeals, Eighth Circuit.

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[1] The HONORABLE RICHARD H. KYLE, United States District Judge for the District of Minnesota.

APPENDIX B

[Filed Aug. 8, ~~1995~~]

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

Civil No. 3-94-1522

ST. PAUL RAMSEY MEDICAL CENTER, INC.,
Plaintiff,

vs.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Defendant.

MEMORANDUM OPINION AND ORDER

Introduction

Plaintiff commenced this action challenging Medicare regulations issued by the Department of Health and Human Services ("HHS" or "agency") pursuant to 42 U.S.C. § 1395ww(h)(2)(a) which implement a new methodology for reimbursing graduate medical education costs incurred by teaching hospitals. This matter is currently before the Court on the parties' cross motions for summary judgment. The Court will grant the Defendants Motion and uphold the agency's regulations.

Background [1]

Congress established the Medicare program, 42 U.S.C. §§ 1395 *et seq.*, to provide health insurance to the elderly and disabled. Part A of this program provides insurance for covered inpatient and related post-hospital services. Under Medicare regulations, a hospital may be reimbursed for the costs of certain educational programs for health care professional trainees, including programs for interns and residents known as graduate medical education ("GME") programs. 42 C.F.R. 413.85(a). Until 1985, participating hospitals were reimbursed for costs incurred in furnishing GME services based on the "reasonable cost . . . actually incurred." 42 U.S.C. § 1395x (v)(1)(A).

In April, 1986, Congress enacted legislation establishing a new GME cost reimbursement system. *See* Pub. L. No. 99-272, 100 Stat. 153-155 *et seq.*, 42 U.S.C. § 1395ww(h). The statute provided that:

> The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospitals for each full-time-equivalent resident.

Id. The HHS was directed to calculate a per-resident amount for each hospital by dividing the amount of GME costs recognized as reasonable for the base period of 1984 (numerator) by the number of full-time equivalent interns and residents working at the hospital in 1984 (denominator). To determine a hospital's GME reimbursement in future years, the 1984 base period per-resident

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[1] The statutory and regulatory background surrounding the pertinent issue in this case is more fully set forth in *Administrators of the Tulane Educ. Fund. v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 114 S. Ct. 740 (1994) and *Toledo Hosp. v. Secretary of Health and Human Serv.*, No. 3:94cv7080, (N.D. Ohio, June 23, 1995).

amount, adjusted for inflation, would be multiplied by the number of full-time-equivalent residents during the year in question, and that product would be multiplied by the hospital's Medicare patient load in that same year. 42 U.S.C. § 1395ww(h)(3).

On September 29, 1989, HHS promulgated final regulations ("reauditing regulation(s)") implementing the new GME reimbursement rules established in the 1986 statute. *See* 54 Fed. Reg. 40,286, codified at 42 C.F.R. § 413.86. By the time this regulation was issued, however, most hospitals had already been reimbursed for 1984 GME costs. Nevertheless, the regulations directed Medicare fiscal intermediaries (usually insurance companies) to reexamine or "verify" GME costs from the base year (1984) and to conduct a reaudit of the costs allowed for the base year if the claimed base year appeared to include "misclassified or nonallowable costs," or if the costs for the base year appeared "unreasonably high." 54 Fed. Reg. at 36,591.

The Plaintiff in this case claims this "reauditing" procedure is invalid. The Plaintiff claims that the terms "average amount recognized as reasonable under this subchapter" in 42 U.S.C. § 1395ww(h)(2)(A) refer specifically to the amount which had been derived from the standard cost reporting and review process following the close of the 1984 fiscal year. As a result, Plaintiff contends that a recalculation of this figure is not permissible and that the reaudit regulation contained in 42 C.F.R. § 413.86 is therefore invalid.

This Court has jurisdiction over this matter pursuant to 28 U.S.C. § 1331.

Discussion

Plaintiff has made the following arguments in support of its challenge to the HHS's reauditing regulation:

(1) The reauditing regulation is not entitled to the traditional deference afforded to agency regulations under the standard set forth in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) because the language of 42 U.S.C. § 1395ww(h)(2)(A) unambiguously requires the HHS to use the figure derived from the standard cost reporting and review process following the close of the 1984 fiscal year and not a "recalculated" figure, and, as a result, the regulation is invalid;

(2) The reauditing regulation is invalid because it is an unreasonable interpretation of § 1395ww(h)(2)(A); and

(3) The reauditing regulation is a "retroactive rule" not specifically required under § 1395ww(h)(2)(A) and is thus invalid under *Landgraf v. USI Film Products*, 114 S. Ct. 1483 (1994) and *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988).

Plaintiff's challenge to the HHS's reaudit regulation, 42 C.F.R. § 413.86, has been considered and rejected by both the Court of Appeals for the District of Columbia and the United States District Court for the Northern District of Ohio. *See Administrators of the Tulane Educ. Fund. v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 114 S. Ct. 740 (1994); *Toledo Hosp. v. Secretary of Health and Human Serv.*, No. 3:94cv7080, (N.D. Ohio, June 23, 1995). *Tulane* and *Toledo Hospital* concluded: (1) the language of 42 U.S.C. § 1395ww(h)(2)(A) was ambiguous and did not require the HHS to use the figure derived from the standard cost reporting and review process following the close of the 1984 fiscal year; (2) the reauditing regulation was a reasonable interpretation of § 1395ww(h)(2)(A); and (3) the reauditing did not impose an impermissible "retroactive rule."[2] The

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[2] *Tulane* was decided prior to *Landgraf v. USI Film Products*, 114 S. Ct. 1483 (1994). However, the Court finds *Landgraf* does

Plaintiff does not distinguish *Tulane* and *Toledo Hospital*, but asserts that they were incorrectly decided. The Court has carefully reviewed the Plaintiff's arguments. The Court finds the opinions in *Tulane* and *Toledo Hospital*, although not binding, to be persuasive, thorough, well-reasoned and indistinguishable from the present case. No useful purpose would be served by a third detailed analysis of the issues presented here. The Court is satisfied with the legal analyses of the *Tulane* and *Toledo Hospital* opinions and adopts them here. There being no genuine issue of material fact, Defendant is entitled to judgment as a matter of law.

Conclusion

Accordingly, based on the foregoing, and upon all the files, records and proceedings herein, IT IS ORDERED that:

(1) Plaintiff's Motion for Summary Judgment (Doc. No. 12) is DENIED;

(2) Defendant's Motion for Summary Judgment (Doc. No. 15) is GRANTED; and

(3) Plaintiff's Complaint (Doc. No. 1) is DISMISSED WITH PREJUDICE.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: August 8, 1995

/s/ Richard H. Kyle
RICHARD H. KYLE
United States District Judge

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not affect *Tulane*'s conclusion regarding the reauditing regulation's alleged retroactive effect. The Court also notes that, in upholding the regulation, *Toledo Hospital* considered its alleged retroactivity in light of *Landgraf*. *See Toledo Hosp. v. Secretary of Health and Human Serv.*, No. 3:94cv7080, slip op. at 13-15 (N.D. Ohio, June 23, 1995).

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 95-3477MNST

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Appellant,

v.

DONNA E. SHALALA, ETC.,
Appellee.

Appeal from the United States District Court
for the District of Minnesota

ORDER

The petition for rehearing filed by the appellant has been considered by the court and is denied.

September 30, 1996

Order Entered at the Direction of the Court:

/s/ Michael E. Gaus
Clerk
U.S. Court of Appeals
Eighth Circuit

APPENDIX D

STATUTES AND REGULATIONS INVOLVED

1. 42 U.S.C. § 1395ww(h) provides in relevant part:

(h) Payments for direct graduate medical education costs

(1) Substitution of special payment rules

Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B of this subchapter (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) Determination of hospital-specific approved FTE resident amounts

The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) Determining allowable average cost per FTE resident in a hospital's base period

The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) Updating to the first cost reporting period

(i) In general

The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

* * * *

(E) Treatment of certain hospitals

In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this subchapter for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this subchapter, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(3) Hospital payment amount per resident

(A) In general

The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital medicare patient load (as defined in subparagraph (C)) for that period.

(B) Aggregate approved amount

As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

(C) Medicare patient load

As used in subparagraph (A), the term "medicare patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A of this subchapter.

(4) Determination of full-time-equivalent residents

(A) Rules

The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) Adjustment for part-year or part-time residents

Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

(C) Weighting factors for certain residents

Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) Foreign medical graduates required to pass FMGEMS examination

(i) In general

Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the

Educational Commission for Foreign Medical Graduates.

(ii) Transition for current FMGS

On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) Counting time spent in outpatient settings

Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(5) Definitions and special rules

As used in this subsection:

* * * *

(F) Initial residency period

The term "initial residency period" means the period of board eligibility plus one year, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

The initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

* * * *

2. 42 U.S.C. § 1395oo provides in relevant part:

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter rereferred to as the "Board") * * * if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report

* * * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received.

* * * *

Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

3. 42 U.S.C. § 1395ww(a)(1)(C) provides:

The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

4. 42 U.S.C. § 1395ww(b)(3)(A) provides:

Except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable

operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

5. 42 C.F.R. § 405.481(g) (1995) provides in relevant part:

(g) *Recordkeeping requirements.* * * *, each provider that claims payment for services of physicians under this subpart must:

* * * *

(3) Retain each physician compensation allocation, and the information on which it is based, for at least four years after the end of each cost reporting period to which the allocation applies.

6. 42 C.F.R. § 405.1803(a)(1) provides:

Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report; and

(ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

7. 42 C.F.R. § 405.1807 provides:

Effect of intermediary determination.

The determination shall be final and binding on the party or parties to such determination unless:

(a) An intermediary hearing is requested in accordance with § 405.1811 and an intermediary hearing decision rendered in accordance with § 405.1831; or

(b) The intermediary determination is revised in accordance with § 405.1885; or

(c) A Board hearing is requested in accordance with § 405.1835 and a hearing decision rendered pursuant thereto.

8. 42 C.F.R. § 405.1885(a) provides in relevant part:

A determination of an intermediary * * * may be reopened with respect to findings on matters at issue in such determination * * * by such intermediary officer * * * either on motion of such intermediary officer * * * or on the motion of the provider affected by such determination * * * to revise any matter in issue at any such proceedings. * * * any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

9. 42 C.F.R. § 413.86(e)(1) provides in relevant part:

Determining per resident amounts for the base period—(1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

* * * *

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

* * * *

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 95-3858

THE TOLEDO HOSPITAL,
Plaintiff-Appellant,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Defendant-Appellee.

On Appeal from the United States District Court
for the Northern District of Ohio

Decided and Filed January 13, 1997

Before: BOGGS and NORRIS, Circuit Judges; HOOD, District Judge.*

ALAN E. NORRIS, Circuit Judge. At issue in this case is the validity of the Medicare reaudit regulation, 42 C.F.R. §§ 413.86(e)(1)(ii)-(iii). For the following reasons, we conclude that the reaudit regulation is invalid under the guidelines set out by the Supreme Court in

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* The Honorable Joseph M. Hood, United States District Judge for the Eastern District of Kentucky, sitting by designation.

Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).

I. Regulatory Framework

From 1965 to 1986, the Medicare program reimbursed participating hospitals, known as providers, for the reasonable costs incurred in furnishing graduate medical education ("GME"). The Secretary of Health and Human Services (the "Secretary") delegated the task of administratively determining these costs to fiscal intermediaries. The procedure for determining a provider's reasonable costs for GME involved several steps. First, providers would submit a cost report to a fiscal intermediary shortly after the end of the reporting year. *See* 42 C.F.R. § 413.24(f)(2)(i) (1995). The fiscal intermediary would then issue a notice of program reimbursement (an "NPR"). *See* 42 C.F.R. § 405.1803(a) (1995). A provider dissatisfied with the allowed costs could appeal the intermediary's determination to the Provider Reimbursement Review Board (the "Board"). *See* 42 U.S.C. § 1395*oo*(a)(1); 42 C.F.R. § 405.1835(a) (1995). Judicial review of final decisions of the Board was authorized by 42 U.S.C. § 1395*oo*(f)(1).

To aid in the audit and review of providers' claims, the Secretary required each provider to retain records pertaining to its physicians' compensation, as well as the amount of time each physician devoted to Medicare versus non-Medicare duties. 42 C.F.R. § 405.481(g)(3) (1995), *removed*, 60 Fed.Reg. 63,124, 63,175 (1995). The Secretary required that such records be retained for at least four years after the end of each cost reporting period to which the allocation applies. *Id.* To further ensure the accuracy of the audit process, the Secretary allowed for the reopening of a cost determination within three years of the last administrative action taken with respect to the year in question. *See* 42 C.F.R. § 405.1885 (a) (1995).

In April of 1986, Congress enacted the Comprehensive Omnibus Budget Reconciliation Act of 1986 (the "Act"), Pub. L. No. 99-272, 1986 U.S.C.C.A.N. (100 Stat.) 82. Among the changes adopted, the Act converted GME reimbursements from a pass-through basis to a per-resident reimbursement indexed to a base year. Section 9202(a) of that act amended § 1886 of the Social Security Act, 42 U.S.C. § 1395ww, by, among other things, enacting 42 U.S.C. § 1395ww(h)(2)(A), the current version of which reads as follows: "The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 1986 U.S.C.C.A.N. (100 Stat.) at 171-72 (the "GME amendment"). Section 9202(a) further provides that the base year per-resident average would be adjusted for inflation and used to calculate GME reimbursements for future years. *See* 42 U.S.C. §§ 1395ww(h)(2)(C)-(D) Section 9202(b) of the Act provides that the amendments in § 9202(a) "shall apply to hospital cost reporting periods beginning on or after July 1, 1985." 1986 U.S.C.C.A.N. (100 Stat.) at 175.

While the Act was passed in April of 1986, the Secretary waited until September of 1989 to adopt implementing regulations. *See* 54 Fed. Reg. 40,286, 40,316-17 (1989) (Codified at 42 C.F.R. § 413.86(e)(1)). These regulations first instruct the fiscal intermediaries to verify that the costs allowed for each provider for the base year, fiscal year 1984, are accurate and to exclude any costs improperly allowed in the initial audit. *See* 42 C.F.R. §§ 413.86(e)(1)(i)-(ii) (1995). The regulations then address GME cost determinations that are more than three years old and, therefore, are no longer subject to reopening: "If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify

the hospital's base-period costs solely for purposes of computing the per resident amount." 42 C.F.R. § 413.86 (e)(1)(iii) (1995) (together with 42 C.F.R. § 413.86 (e)(1)(ii), the "reaudit regulation"). Thus, finding that a provider's 1984 GME costs were too high would not require repayment from the provider for that year if the reaudit occurred after the end of the reopening period. Because many providers had disposed of their records for 1984 after having retained the documents for the requisite four-year period, the Secretary allowed providers who no longer had their 1984 records to submit information from subsequent years as evidence of the number of residents and the percentage of time dedicated to Medicare activities for the base year. *See* 55 Fed. Reg. 35,990, 36,063-64 (1990).

II. Facts

Plaintiff, The Toledo Hospital (the "Hospital"), uses the calendar year as its fiscal year. Accordingly, its base year for purposes of the Medicare regulations ended on December 31, 1984. On February 26, 1986, a fiscal intermediary issued the NPR for 1984, recognizing that the Hospital was entitled to $5,867,705 in reasonable GME costs. The Hospital did not appeal that finding to the Board, and the three-year reopening period for the 1984 determination ended on February 26, 1989. Under the four-year record-keeping requirement, the Hospital was required to retain its physician compensation records for 1984 until December 31, 1988.

Pursuant to the reaudit regulations adopted in September of 1989, a fiscal intermediary began a reaudit of the Hospital's base year in late 1990. On January 31, 1991, the intermediary found that the initial determination of the Hospital's base-year cost was nearly forty percent too high and that the appropriate GME costs for 1984 were $4,278,371. Based upon this adjusted cost figure and the number of full-time-equivalent residents for 1984, the intermediary determined an average per-resident GME

amount that results in substantially lower GME reimbursements to the Hospital for cost years beginning on January 1, 1986, than would have been the case if the original cost figure had been used.

The Hospital appealed the fiscal intermediary's reaudit calculation to the Board. On December 17, 1993, the Board ruled that it lacked authority to decide the validity of the Secretary's reaudit regulation, thereby allowing for immediate judicial review in the district court. *See* 42 U.S.C. § 1395*oo*(f)(1). Shortly thereafter, the Hospital filed this suit in the United States District Court for the Northern District of Ohio seeking both declaratory and injunctive relief. The Hospital argued that (1) the reaudit regulation is impermissibly retroactive, (2) the regulation conflicts with the Medicare statute, and (3) the regulation is arbitrary and capricious. On March 27, 1995, the Hospital filed a motion for summary judgment, and the Secretary filed a cross-motion for summary judgment on March 30, 1995. On June 23, 1995, the district court issued an order granting summary judgment in favor of the Secretary and denying the Hospital's summary judgment motion. The Hospital filed this appeal.

III. *Chevron* Analysis

We review the district court's grant of summary judgment de novo. *See Holiday Inns, Inc. v. 800 Reservation, Inc.*, 86 F.3d 619, 622 (6th Cir. 1996). Because the denial of the Hospital's motion for summary judgment was based entirely upon a ruling of law, rather than the presence of factual issues for trial, we review that decision de novo as well. *See Greene v. Reeves*, 80 F.3d 1101, 1104 (6th Cir. 1996). The familiar standard for assessing the validity of federal regulations appears in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984):

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.
>
> If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. at 842-43 (footnotes omitted). Moreover, "[i]f a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect." *Id.* at 843 n.9.

The Hospital argues that *Chevron* does not apply in the present case because of the retroactive nature of the reaudit regulation. Although courts generally do not defer to retroactive agency regulations when the statutes that they implement do not require retroactive application, the reaudit regulation does not amount to an impermissible retroactive regulation. In *Landgraf v. USI Film Products*, 114 S. Ct. 1483 (1994), the Supreme Court defined the test for retroactivity as "whether the new provision attaches new legal consequences to events completed before its enactment." *Id.* at 1499. While the reaudit regulation does require a determination based upon events occurring in the base year, it does not change the standards under

which the base year costs are to be determined. Thus, we believe that *Chevron* applies in this case.

A. Step One: Plain Meaning

The first step in the *Chevron* analysis is to determine whether Congress has expressed an intent on the issue at hand. That intent can appear in the language of the statute, or it can become apparent in light of the statutory scheme taken as a whole. The GME amendment directs the Secretary "to determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. § 1395ww(h)(2)(A). The Hospital contends that the plain meaning of this language prohibits the Secretary's reaudit regulation, which directs the fiscal intermediaries to recalculate the 1984 GME costs even after the three-year reopening period has expired.

Determining whether a statute is unambiguous is not always an easy matter. The first court to address the validity of the reaudit regulation, the District Court for the District of Columbia, held that the regulation contradicts the plain language of the statute. *See Methodist Hosps. v. Sullivan*, 799 F. Supp. 1210, 1216-17 (D.D.C. 1992), *rev'd sub nom. Administrators of the Tulane Educ. Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994). In reversing the district court, however, the Court of Appeals for the District of Columbia discovered ambiguity in the words "determine," "recognized as reasonable," and "under this subchapter." *Administrators of the Tulane Educ. Fund v. Shalala*, 987 F.2d 790, 794-96 & n.6 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994). The next three courts to address this issue, beginning with the district court in the case at bar, relied heavily upon the reasoning in *Tulane* and concluded that the statute is ambiguous. *See Toledo Hosp. v. Shalala*, No. 3:94CV7080, slip op. at 8-9 (N.D. Ohio June 23, 1995); *St. Paul Ramsey Medical Ctr., Inc. v. Shalala*, 1995 WL 879969, at 2 (D. Minn. Aug. 8, 1995), *aff'd*, 91 F.3d 57 (8th Cir. 1996); *St. Paul-Ramsey Medical Ctr., Inc. v. Shalala*, 91 F.3d 57 (8th Cir. 1996).

Before proceeding with our own examination of the GME amendment, we consider it worthwhile to review the approaches taken by the two courts of appeals that have had occasion to address the validity of the reaudit regulation. The Court of Appeals for the District of Columbia in *Tulane* began its analysis with the following summary:

> [W]e do not believe that Congress spoke directly to the precise question of whether HHS should, in determining the base period GME per resident amount, automatically adopt the GME sum approved for reimbursement to hospitals for 1984 or whether it retained the residual authority to reassess at a later date the reasonableness of that calculation for prospective use only. *Given this ambiguity*, we find that HHS reasonably determined that Congress would not likely have wished misclassified and nonallowable costs inadvertently reimbursed to hospitals for fiscal year 1984 to be "cemented" into the base period amount and indefinitely carried forward in the formula for future reimbursements. *To avoid that eventuality, HHS must retain the ability to revisit its 1984 reimbursements for error*, even though those figures had previously been found reasonable, since the sole purpose of the reauditing was to calculate the base period formula applicable under the 1986 statute for fiscal year 1985 and later years.

987 F.2d at 792 (emphasis added).

The court identified the crux of the matter as follows:

> The issue thus devolves into whether, assuming its knowledge of the long-standing regulation providing

> for a three year period for reopening approved costs, 42 C.F.R. § 405.1885, Congress in enacting the 1986 GME Amendments left some leeway for the eventuality that HHS might not be able to promulgate and implement regulations governing the new methodology until after that three year period had lapsed, or whether, even if the new regulations should be delayed until after the three year period, Congress clearly intended to prohibit the Secretary from reauditing the 1984 costs for past errors in order to establish an accurate base period per resident amount.

Id. at 794. The court then identified the purpose of the 1986 statute as to establish "a new and presumably more accurate methodology for reimbursing GME costs . . . ." *Id.* at 795. The court concluded that there is no evidence that Congress meant to preclude the Secretary from revisiting the 1984 cost determinations.

The court then went on to note that the statutory language is ambiguous:

> Finally, and perhaps most importantly, the relevant phrase "amount recognized as reasonable under this subchapter" is on its face ambiguous. We know only one thing for sure, that it certainly could not have included any amounts already finally approved before the statute was enacted since, in 1986, every hospital's 1984 NPR was still subject to the three year reopening period. *See* 42 C.F.R. § 405.1885. But beyond that given, it is decidedly unclear that the statute meant to allow the Secretary to use only the GME cost figure that would emerge as reasonable through the regular NPR review and three year reopening process. It might just as well have permitted the Secretary the option of using a figure that would be "recognized as reasonable under this title" at a later time after more careful assessment.

Id. at 796.

In a footnote, the court also considered the ambiguity of the word "determine":

> We also note that because the statute directs the HHS to "determine" the "average amount" of GME costs per FTE resident "recognized as reasonable," it seems unlikely that Congress intended for the HHS to simply look up a hospital's approved NPR for 1984 and plug it into the statutory formula. This activist language suggests that Congress must have intended for the agency to make some kind of substantive calculation on its own, which might involve as well a current assessment of the reasonableness of prior determinations.

Id. at 796 n.6.

The Court of Appeals for the Eighth Circuit explicitly adopted the reasoning of *Tulane* in *St. Paul-Ramsey Medical Ctr., Inc. v. Shalala*, 91 F.3d 57, 58 (8th Cir. 1996).

With due respect to our sister courts, we believe that the approach taken by the court in *Tulane* misperceives the policy underlying *Chevron* deference. *Chevron* instructs courts to accept a reasonable administrative interpretation of a statute where Congress has delegated decisional autonomy to an agency. When Congress intentionally leaves gaps and ambiguous terms in a statute for the agency to flesh out, the principle of separation of powers counsels that this legislative delegation be respected by the judiciary. It is an entirely different matter, however, to presume a delegation of interstitial rulemaking authority when the claimed ambiguity in the statute stems not from the use of a word with several plausible interpretations, nor from the statute's lack of specificity regarding mundane procedural issues, but from nothing more than the failure of Congress to proscribe explicitly an unusual procedure which may be plainly at odds with the result Congress was trying to reach.

It seems to us that when the court in *Tulane* parsed the GME amendment, it failed to accord proper attention and

importance to the word "average," a term that is critical to understanding congressional intent. The GME amendment, in establishing a reimbursement scheme keyed to a base-year figure, introduced the concept of the per-resident average cost. This concept had not been used previously in the calculation of reimbursements and became the basis for all future payouts. Upon fulfilling the obligation imposed by the GME amendment, the Secretary would arrive at this number, the per-resident average, which would then be adjusted for inflation and utilized to determine future reimbursements. Given the introduction of this entirely new cost concept, we do not believe that the *Tulane* court was warranted in seizing upon the word "determine" as "activist language" that would authorize agency action that goes far beyond a simple calculation of the per-resident average based upon 1984 figures arrived at through the normal administrative process. *See Tulane*, 987 F.2d at 796 n.6.

We also see no ambiguity in the language "recognized as reasonable under this subchapter." While the court in *Tulane* felt that the temporal focus of this language was open-ended, thereby permitting the incorporation of substantive regulatory standards formulated at any time, including after the enactment of the GME amendment, that interpretation is strained at best. While we agree that the use of the past participle "recognized" does not restrict the Secretary to using numbers that had been finally determined prior to the passage of the GME amendment, as all of the base-year determinations were still subject to administrative reopening in 1986, there is no basis for the additional inferential leap that the Secretary was therefore free to "recognize" these costs at any time in the future and in a manner utterly detached from the established procedural framework.

When Congress passed the GME amendment in 1986, it knew that there was an administrative scheme in place that would determine the reasonable GME costs for pro-

viders for fiscal 1984. And one must assume that Congress also knew that the 1984 determinations would remain subject to reopening for over a year under the Secretary's existing regulations. It follows that Congress must have contemplated that the Secretary would use those administratively determined reasonable costs as the basis for calculating the average GME cost per full-time-equivalent resident. Indeed, it seems unlikely that Congress, having chosen for its benchmark a cost year still subject to reopening under the existing Medicare regulations, would have been contemplating anything else when it passed the amendment.

The strongest argument for ambiguity may stem from an inference that, because Congress must have understood that regulations might not be forthcoming until after the 1984 cost determinations had ceased to be subject to reopening, it intended that the Secretary would have the authority to reaudit the base-year numbers. That argument is circular, however, as it presupposes that Congress intended the GME amendment to require a reassessment of the 1984 costs. Only if the amendment would assign to the Secretary a new and substantial administrative burden would there be a congressional expectation that implementing regulations would take any real time to formulate. The Secretary argues that a three-year delay in enacting implementing regulations is understandable and foreseeable in light of the "complex statutory scheme," a phrase that seems to be invoked any time a statute occupies more than a page of the United States Code. However, the statute and its contemplated result are not at all complex. A major overhaul of the Medicare system might entitle the Secretary to consume a considerable amount of time in preparing regulations. That surely is not the case with the GME amendment, which merely directs the Secretary to divide one number by another. Moreover, if, as it seems clear to us, Congress intended the actual 1984 costs to be plugged into the per-resident average calculation, it was not attempting to create work

for the Secretary with respect to the cost determination. And it follows that, since there was no such extra work contemplated and there was no reason to suppose that promulgating regulations would consume three years, there was no reason to address in the statute the specific issue of authority to reaudit closed base years.

What the Secretary is really saying is that Congress must have contemplated that the administrative mechanism to determine reasonable GME costs, created by Congress and implemented by the Secretary's regulations, might not work as well as planned. The Secretary's argument concedes that her agents, the fiscal intermediaries, were not as diligent as they could have been when they initially audited the 1984 numbers. The rationale offered by the Secretary is that because each year's cost determination formerly had no impact beyond that year, it was not as important at that time to get the numbers exactly right. Only now, when Congress has designated a base year that will affect future reimbursements, has it become essential that the fiscal intermediaries root out errors. However, when the statutory language is read in the context of the circumstances surrounding its adoption, it is difficult to come to any conclusion other than that Congress anticipated that the administrative scheme already in place would function properly and arrive at the true reasonable GME costs for fiscal 1984 and that these numbers would then be divided by the number of residents to yield the per-resident average costs. Congress could not have foreseen the Secretary's delay in issuing the regulations and her claim that the initial 1984 cost determinations were unreliable. Otherwise, it might well have authorized the reaudit scheme, or simply have selected a different base year.

The Secretary suggests that there was no choice but to reaudit, given the delay in issuing the regulations. It would not be "reasonable" under the GME amendment, the argument runs, to use a base-year cost figure that had

since been discovered to be unreliable, so the statute required a recalculation. The answer to that argument is that the Secretary was without authority to issue the reaudit regulation. The Secretary should have either used the administratively determined 1984 figure or informed Congress of the need for further legislation.

The intent of Congress in enacting the GME amendment should also be considered in the context of the traditional presumption of issue preclusion with respect to administrative findings, since "Congress is understood to legislate against a background of common-law adjudicatory principles." *Astoria Fed. Sav. and Loan Ass'n v. Solimino*, 501 U.S. 104, 108 (1991). It seems to us that, absent some indication from Congress that administrative findings were not to be given preclusive effect, courts should be hesitant to permit administrative agencies to require a party to reestablish or relitigate factual matters that have already been determined with finality. *See id.* at 107-08. We are unable to accept the Secretary's suggestion that estoppel does not apply because the incentive to determine the issue correctly did not exist during the initial audits, or was not as strong, when each year's cost determination had no effect beyond that year. *See United States v. Berman*, 884 F.2d 916, 922-23 (6th Cir. 1989). After all, the Secretary was directed by statute to determine the reasonable costs for GME, a factual question identical to the determination in the reaudit regulation and one that the Secretary was required by law to resolve. The absence of statutory language negating the presumption of issue preclusion strongly suggests that Congress intended the Secretary to use the 1984 costs derived through the ordinary administrative process.

Finally, it is difficult to imagine that, had Congress intended the result urged by the Secretary, it would have used the language that ultimately found its way into the statute. Instead, a statute focusing on reaudits possibly leading to new, reasonable cost figures, could be expected to include directions to the Secretary to "determine, for

the hospital's cost reporting period that began during fiscal year 1984, the amount recognized as reasonable under this subchapter for graduate medical education and the average cost of graduate medical education for each full-time-equivalent resident," or something similar. Surely, such a statute would not, as did the actual GME amendment, direct the Secretary to "determine" solely "the average amount." It seems apparent that the only substantive calculation contemplated by the statute is this per-resident average, and there is no basis for asserting that the 1984 figures should be reassessed outside the existing administrative scheme.

Under *Chevron* analysis, a regulation does not survive the first step merely because there is a metaphysical possibility that the statute could be read in the manner advocated by the agency. The GME amendment does not, by its terms, explicitly proscribe the reaudit that occurred in this case. Nevertheless, the statutory framework, as well as the regulations in place at the time that the GME amendment was enacted, provide clear illumination of the will of Congress. When this court can readily discern that an agency has strayed from the path intended by Congress, the inference of legislatively delegated authority vanishes. In the absence of delegated authority, *Chevron* deference is not warranted. Accordingly, we believe that the reaudit regulation is inconsistent with the legislative intent behind the GME amendment, and thus that it fails under the first prong of *Chevron*.

B. Step Two: Reasonableness

When a regulation satisfies step one of *Chevron*, the analysis shifts to a determination of whether the agency's construction of its statute is reasonable. The review for reasonableness examines whether the agency properly exercised its discretion within the sphere of its delegated authority. Review of this question centers on whether the agency action either "fills a gap" or otherwise fits within

"the legislature's revealed design." *NationsBank of North Carolina v. Variable Annuity Life Ins. Co.*, 115 S. Ct. 810, 813-14 (1995). Although we have concluded that the reaudit regulation fails at the first step of *Chevron*, we hold in the alternative that the reaudit regulation is an unreasonable interpretation of the GME amendment.

The two key considerations that led the court in *Tulane* to conclude that the reaudit regulation satisfies the second prong of *Chevron* were (1) the interest in preventing erroneous cost determinations from being perpetuated in the form of excessive future reimbursements and (2) the time needed by the Secretary to regulate within a "complex statutory scheme." *Tulane*, 987 F.2d at 797. The Secretary argues that a failure to reaudit would have been unreasonable, given the presumed intent of Congress to eliminate mistakes in the base-year calculations. The Secretary notes that the reaudits have resulted in many instances in findings of much lower base-year costs than were originally determined through the normal administrative mechanism. The Secretary also argues that it could have amended the reopening regulation to allow for a longer reassessment window. The district court in this case also stressed that the hospitals had at least some notice of the possibility of reauditing, *see* 53 Fed. Reg. 36,589, 36,591-92 (1988), and thus should have retained their physician compensation allocation records beyond the four-year period.

The Hospital responds that, because (1) the records have been disposed of, (2) many of the relevant hospital personnel have moved to other jobs, and (3) memories of what specific duties residents performed in 1984 have faded, there is no way that a reaudit would produce a more accurate assessment of 1984 costs than did the initial audits. As for the lower costs determined by the reaudits, the Hospital argues that the result necessarily follows from the absence of supporting documentation. Only those costs that could be proved were allowed in the reaudit,

and without any records the Hospital could no longer prove as much of its GME costs as it was able to do in the original audit.

The Secretary is obviously correct that Congress did not want faulty base-year calculations to be perpetuated. What the Secretary fails to recognize is that Congress expected the Secretary to get the calculations right the first time. There is no claim that the Hospital tried to deceive the fiscal intermediary by submitting a fraudulent cost report for 1984, and the regulations expressly allow for reopening at any time where fraud is shown. *See* 42 C.F.R. § 405.1885(d) (1995). The Secretary simply claims that it was swamped with work, including coping with earlier amendments to the Medicare statute, that resulted in less attention being paid to the initial cost determinations for 1984. We believe that the principle of issue preclusion prevents the Secretary from requiring providers to reestablish the costs that they already proved years ago.

The other significant problem with the Secretary's argument is that the whole reaudit issue arose because the Secretary waited three years before issuing regulations. Had the Secretary acted promptly, there would have been no need to revisit any closed determinations, because all of the 1984 numbers were still subject to reopening for some time after the passage of the GME amendment. Even after the Secretary recognized that there might be problems with the 1984 numbers and that reaudits may be necessary, there was a delay of at least a year before the reaudit regulation was enacted. *See* Fed. Reg. 36,589, 36,591-92 (1988) (indicating that errors had been made in previous audits). During that year, many, if not most, of the 1984 determinations ceased to be subject to reopening.

The bottom line is that the Secretary's response to the GME amendments has been unreasonable on all counts. The Secretary read the amendments as requiring a substantive reevaluation of the 1984 numbers. The Secretary waited far too long to issue regulations, justified solely by the nebulous assertion of statutory and regulatory complexity. While there was a brief mention in the Federal Register of the possibility of reaudits once the Secretary came to suspect that the base-year calculations may have been flawed, those comments cannot be considered notice of the need to retain physician allocation and compensation records when all that the Secretary would have had to do to mitigate the harm here was to (1) extend the reopening period, (2) extend the record-keeping period, or (3) reopen all of the 1984 determinations. The Secretary ignored the principle of collateral estoppel and the basic fairness issues implicated. Finally, the Secretary ordered the reaudits to occur only after the providers had been permitted to dispose of the records necessary to allow for a meaningful audit.

The predicament was of the Secretary's making and it is unreasonable to expect the Hospital to answer for it. Accordingly, we believe that the reaudit regulation fails step two of *Chevron*.

IV. Conclusion

The judgment of the district court, granting summary judgment to the Secretary and denying summary judgment to the Hospital, is **reversed**. The cause is **remanded** with instructions to grant summary judgment to the Hospital.

APPENDIX F

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 92-5281

ADMINISTRATORS OF THE TULANE EDUCATIONAL FUND,
d/b/a TULANE MEDICAL CENTER HOSPITAL AND CLINIC,
Appellee

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant

No. 92-5282

METHODIST HOSPITALS OF MEMPHIS,
Appellee

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant

No. 92-5283

GEORGE WASHINGTON UNIVERSITY HOSPITAL,
Appellee

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant

No. 92-5284

LUCY WEBB HAYES NATIONAL TRAINING SCHOOL
FOR DEACONESSES AND MISSIONARIES, A CORPORATION,
Appellee

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant

No. 92-5285

GREATER SOUTHEAST COMMUNITY HOSPITAL;
FAIRFAX HOSPITAL,
Appellees

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant

Argued January 19, 1993
Decided March 9, 1993

Appeal from the United States District Court
for the District of Columbia

(Civil Action Nos. 92cv01120, 92cv00009,
92cv00041, 92cv00870 and 92cv00989)

Before WALD, RUTH B. GINSBURG and D.H. GINSBURG, *Circuit Judges.*

Opinion for the Court filed by *Circuit Judge* WALD.

WALD, *Circuit Judge:* The Department of Health and Human Services ("HHS" or "agency") appeals the district court's decision invalidating the agency's 1989 regulations implementing a new statutory methodology, enacted by Congress in 1986, for reimbursing teaching hospitals for the graduate medical education ("GME") costs attributable to Medicare services. Under the statute, HHS is to determine, for fiscal year 1984, the average per resident amount of GME costs "recognized as reasonable" for each hospital, and then to use this 1984 base period figure to calculate the hospital's GME reimbursements for all subsequent years. The agency interpreted this statutory directive as permitting it to reexamine and reaudit previously approved, but possibly erroneous or unreasonable, 1984 GME costs, and promulgated reauditing regulations to that effect. Appellees, a group of six hospitals which receive Medicare funds ("Hospitals"),[1] successfully brought a facial challenge to the regulations, arguing that the statutory phrase "amount recognized as reasonable" unambiguously required HHS to employ, without modification, previously approved 1984 GME cost figures, and further, that the agency's reaudit regulations were impermissibly retroactive.

We disagree with the district court that the language of the statute is so plain. Specifically, we do not believe that Congress spoke directly to the precise question of whether HHS should, in determining the base period GME per resident amount, automatically adopt the GME sum approved for reimbursement to hospitals for 1984 or whether it retained the residual authority to reassess at

[1] The appellees are Methodist Hospitals of Memphis, George Washington University Hospital, Lucy Webb Hayes National Training School for Deaconesses and Missionaries, the Administrators of the Tulane Educational Fund d/b/a Tulane Medical Center Hospital and Clinic, Greater Southeast Community Hospital, and Fairfax Hospital.

a later date the reasonableness of that calculation for prospective use only. Given this ambiguity, we find that HHS reasonably determined that Congress would not likely have wished misclassified and nonallowable costs inadvertently reimbursed to hospitals for fiscal year 1984 to be "cemented" into the base period amount and indefinitely carried forward in the formula for future reimbursements. To avoid that eventuality, HHS must retain the ability to revisit its 1984 reimbursements for error, even though those figures had previously been found reasonable, since the sole purpose of the reauditing was to calculate the base period formula applicable under the 1986 statute for fiscal year 1985 and later years. Under those circumstances, the readjustment of the 1984 figures did not constitute impermissible retroactive rulemaking. For these reasons, we reverse the district court and uphold the agency's regulations.

I. BACKGROUND

Health care providers that participate in the Medicare program are eligible to be reimbursed for medical education costs associated with an approved GME program that relate to Medicare services. Under previous HHS regulations, providers were required each fiscal year to file a "cost report," including GME costs, with a "fiscal intermediary" designated by HHS. 42 C.F.R. § 405.1801. The intermediary then determined the total amount of reimbursement due the provider in the form of a "notice of program reimbursement" ("NPR"), 42 C.F.R. § 405.1803, which could be challenged by the provider before the Provider Reimbursement Review Board ("Board"). 42 U.S.C. §§ 1395oo(a), (b); 42 C.F.R. §§ 405.1835, 405.1837. The Secretary of HHS could timely reverse, affirm or modify a Board decision. 42 U.S.C. § 1395oo(f)(1). By regulation, the Secretary also could, within three years, reexamine any determination by a fiscal intermediary, the Board or the Secretary. 42 C.F.R. § 405.1885. Finally, providers were entitled to

obtain judicial review of Board decisions and any reversal, affirmance or modification by the Secretary. 42 U.S.C. § 1395oo(f)(1).

Until 1985, hospitals were reimbursed for GME costs under a "reasonable cost" system, 42 U.S.C. § 1395f (b)(1), but in 1985, the HHS promulgated new regulations specifying that hospitals would thereafter be reimbursed for the lesser of allowable costs for the current year or the hospitals' approved costs incurred during fiscal year 1984. 50 Fed. Reg. 27,722 (1985). However, in 1986, Congress itself passed Pub. L. No. 99-272, 100 Stat. 153-155 *et seq.*, 42 U.S.C. § 1395ww(h) ("GME Amendments") which established a new methodology for calculating reimbursements for all periods beginning on or after July 1, 1985. The statute required HHS to first

> determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

42 U.S.C. § 1395ww(h)(2)(A). Thus, HHS was directed to calculate a per resident amount for each hospital by dividing the amount of GME costs recognized as reasonable for the base period of 1984 (numerator) by the number of full-time equivalent ("FTE") interns and residents working at the hospital in 1984 (denominator). For hospitals that had no approved medical residency training program or did not participate in Medicare in 1984, HHS was to determine the "appropriate" per resident amount. 42 U.S.C. § 1395ww(h)(2)(E). To determine a hospital's GME reimbursement for 1985 and future years, the 1984 base period per resident amount, adjusted for inflation, would be multiplied by the number of FTE residents working in the hospital during the year in question, and that product would be multiplied by the

hospital's Medicare patient load in the same year. 42 U.S.C. § 1395ww(h)(3).

By 1989, when HHS promulgated regulations to implement the 1986 GME Amendments, virtually all hospitals had already received NPRs for 1984, and in most cases, the regulatory three year reopening period had expired. Nevertheless, the new regulations permitted the fiscal intermediaries to reaudit the 1984 GME costs and "exclude[] from the base-period graduate medical education costs any nonallowable or misclassified costs," for purposes of determining the "base-period per resident amount." 42 C.F.R. § 413.86(e)(1)(ii). Acknowledging that the three year reopening period had expired for most hospitals, the Secretary stressed that the regulations "indicate[d] that if a hospital's base-period cost report is no longer subject to reopening under § 405.1185, the intermediary may modify the hospital's GME base-period costs *solely* for purposes of computing the per resident amount," and not to adjust the amount owed under the 1984 NPR. 54 Fed. Reg. 40,301 (emphasis added); *see* 42 C.F.R. §§ 413.86(e)(1)(iii). Moreover, the Secretary assured hospitals that "no new reimbursement principles will be applied during the reaudit. Rather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied." 54 Fed. Reg. 40,301 (1989). Finally, hospitals were given 180 days to appeal any determination of their base period per resident amount. 42 C.F.R. § 413.86 (e)(1)(v).

In 1990, the intermediaries began reauditing hospitals' cost reports and found that the allowable 1984 GME amount for each of the six appellee Hospitals was lower than the amount previously approved.[2] For instance, the

[2] The Hospitals complain that they were only required to retain certain records relevant to the reimbursement calculation for four years after the end of a cost reporting period, 42 C.F.R. § 405.481 (g), and therefore, at the time of reauditing, some no longer had

fiscal intermediary for Methodist Hospitals of Memphis ("Methodist") determined that Methodist's allowable 1984 GME costs were $2,785,809, $893,841 less than the $3,679,650 approved by the intermediary in an NPR issued in 1986. Because more than three years had passed since the time the NPRs became final, the reaudits did not result in any recoupment of reimbursements for 1984 but only affected the base period calculation. Methodist appealed to the Board and filed a motion for expedited judicial review on the ground that the Board lacked authority to pass on the validity of the agency's regulations. By statute, the Board has thirty days to rule on such a motion, 42 U.S.C. § 1395oo(f)(1), and when that period expired without a ruling by the Board,[3] Methodist, joined by the five other appellees, filed the present action in district court, challenging the legality of the regulations. The district court ruled for the Hospitals on summary judgment, finding the regulations invalid as contrary to the plain meaning and intent of the GME Amendments and as an unauthorized retroactive rule. *Methodist Hospitals v. Sullivan*, Civil Action Nos. 92cv01120, 92cv00009, 92cv00041, 92cv00870, 92cv00989 Memorandum Opinion ("Mem. op.") (D.D.C. July 17, 1992). The Secretary now appeals that decision.[4]

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this documentation. *See* Appellee's Brief at 9. HHS has responded by permitting the fiscal intermediaries, where necessary, to use records from later years for purposes of calculating the 1984 per resident amount. *See* 55 Fed. Reg. 36,063-64 (1990). The Hospitals do not directly challenge this practice in the present litigation, but they urge that the need to resort to this procedure is evidence of the irrationality of HHS's regulations.

[3] The Board issued an order denying expedited judicial review but did not rule on the validity of the reauditing regulations.

[4] On appeal, the HHS does not question the district court's subject matter jurisdiction. *See* Appellant's Brief at 3 n.2.

II. ANALYSIS

A. *Statutory Intent*

Under the familiar *Chevron* two-step analysis for reviewing an agency's construction of a statute, we ask first "whether Congress has directly spoken to the precise question at issue," and if not, we consider whether the agency's interpretation of the question left open by the statute is a reasonable one. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-44 (1984). Here the district court was confronted with the task of interpreting the statutory directive that HHS "determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. § 1395ww(h)(2)(A). The district court went no further than the first *Chevron* step, concluding that the statutory phrase "amount recognized as reasonable" clearly mandated that HHS use as the base for future payments the 1984 GME costs previously approved by the agency, and that "the plain meaning of the statute does not authorize a reaudit of the 1984 base year costs." Mem. op. at 15. We, however, find it necessary to proceed to the second *Chevron* station because we are not persuaded that the statutory phrase is without ambiguity in the context of the 1986 GME Amendments.

The Hospitals argue their case for nonambiguity on several fronts. First they say, and the district court held, "Congress could not have intended that the Secretary interpret 'recognized as reasonable' to mean two amounts for fiscal 1984: one derived from the standard cost reporting and review process following the close of the fiscal year; and a lower figure recalculated once the Secretary realized that the year would become the base-year for subsequent determinations." Mem. op. at 18. In the district court's view, "[i]f the figures were 'recognized as reason-

able' for the purpose of determining the costs in fiscal year 1984, they must also be recognized as reasonable for subsequent years." *Id.* at 17. The issue thus devolves into whether, assuming its knowledge of the long-standing regulation providing for a three year period for reopening approved costs, 42 C.F.R. § 405.1885, Congress in enacting the 1986 GME Amendments left some leeway for the eventuality that HHS might not be able to promulgate and implement regulations governing the new methodology until after that three year period had lapsed, or whether, even if the new regulations should be delayed until after the three year period, Congress clearly intended to prohibit the Secretary from reauditing the 1984 GME costs for past errors in order to establish an accurate base period per resident amount. The statutory text certainly does not address this administrative dilemma directly, and the Hospitals cite to no legislative history to show that Congress had any intent at all about it. HHS, predictably but persuasively, took the position in promulgating the reaudit regulation that it is "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." 54 Fed. Reg. 40,301 (1989). Indeed, since the GME Amendments were enacted for the purpose of establishing a new and presumably more accurate methodology for reimbursing GME costs, the most natural assumption to be drawn from the statutory silence on the subject would be that Congress did not mean to preclude HHS from correcting past mistakes in the 1984 figure which would govern subsequent payments. In sum, we can find no convincing evidence, direct or indirect, that Congress meant to prohibit corrective reauditing of the 1984 GME cost figures.[5]

[5] The district court also intimated, though the Hospitals do not argue it on appeal, that the fact that Congress did not expressly delegate to the HHS rulemaking authority to determine the "amount recognized as reasonable," whereas it did so authorize the HHS to "establish rules" for computing the number of FTE residents, supports the conclusion that Congress did not intend to allow any reauditing. Mem. op. at 19 (citing 42 U.S.C. § 1395ww(h)(4)(A)). But the two situations are quite different and justify different statutory treatments. The FTE figure was an entirely new concept in the GME Amendments and required HHS to establish a procedure for its calculation. By contrast, the concept of reasonable costs already was a mainstay of Medicare statutes and regulations, *see* 42 U.S.C. § 1395x(v), 42 C.F.R. § 405.1803, and there was no need to establish any new rulemaking authority for its determination.

As a second arrow in their quiver, the Hospitals rely heavily on our decision in *Georgetown University Hospital v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988) ("*Georgetown II*"), which involved a statutory four year transition period beginning in 1983 for shifting from a "reasonable cost" to a "prospective payment" system for Medicare reimbursement of hospital in-patient operating costs. Under the statutory scheme, HHS was to determine reimbursement using hospital-specific rates calculated on the basis of "the allowable operating costs of in-patient hospital services . . . recognized under this subchapter for such hospital for the preceding 12-month cost reporting period." 42 U.S.C. § 1395ww(b)(3)(A). The HHS regulations, however, provided that when a hospital successfully appealed an intermediary's estimation of the 12-month base period costs to the agency or to a court, the finally approved figure would be used as the reimbursement base only in the phase-in year *following* the final decision on review. *Georgetown II*, 862 F.2d at 325. We said, however, in overturning those regulations, that by "allowable" costs Congress meant costs incurred during the reporting period that were finally determined to be allowable after all statutorily-authorized administrative and/or judicial review had been exhausted. *Id.* at 326-27; *see also Tucson Medical Ctr. v. Sullivan*, 947 F.2d 971, 976 (D.C. Cir. 1991). On a "turnabout is fair play" rationale, the Hospitals argue here that an administratively "final" determination that a hospital's 1984 GME costs were reasonable precludes any later reassessment, for any purpose, of that same year's costs.

Georgetown II, while obviously involving similar subject matter, has little bearing on the specific issues in debate here. In that case, we construed the phrase "allowable operating costs . . . recognized under this subchapter" to require HHS to apply a final administrative or judicial decision on the allowability of a particular cost retrospectively to the year under appeal. We simply did not believe that Congress intended that "preliminary estimates [of allowable costs], although administratively necessary, would somehow become final and unalterable before the review process under the statute had been completed." 862 F.2d at 327. The logic underlying our conclusion there was very different from that pressed upon us here by the Hospitals, *i.e.*, that the directive in the GME Amendments to determine the "amount recognized as reasonable" for 1984 precludes HHS from ever reauditing that cost determination *for purposes of computing a base period figure for use in succeeding years*. HHS is in no way attempting here to "effectively cement[] unlawful calculations into the transition year payments by largely insulating them from review," as it was in *Georgetown II*. 862 F.2d at 328. Just the opposite. It is attempting to ensure that misclassified and nonallowable costs approved in NPRs for 1984 are *not* cemented indefinitely into future GME cost reimbursements.

Finally, and perhaps most importantly, the relevant phrase "amount recognized as reasonable under this subchapter" *is* on its face ambiguous. We know only one thing for sure, that it certainly could not have included any amounts already finally approved before the statute was enacted since, in 1986, every hospital's 1984 NPR was still subject to the three year reopening period. *See* 42 C.F.R. § 405.1885. But beyond that given, it is decidedly unclear that the statute meant to allow the Secretary to use only the GME cost figure that would emerge as reasonable through the regular NPR review and three year reopening process. It might just as well have permitted the Secretary the option of using a figure that

would be "recognized as reasonable under this title" at a later time after more careful assessment. *See also Dept. of Treasury v. FLRA*, 960 F.2d 1068, 1072 (D.C. Cir. 1992) ("[The statutory phrase] 'adversely affected' is simply an adjectival phrase, not a verbial phrase indicating the past tense, and hence allows alternative temporal readings. The language, in short, is ambiguous . . . .").[6] In our own review of the statutes governing Medicare reimbursement, we have uncovered at least two other occasions in which Congress has used the phrase "recognized as reasonable." Section 1395x(v), pertaining to the manner in which HHS determines a cost to be reasonable, permits the Secretary to "provide for the establishment of limits [on certain costs] *to be* recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x (v)(1)(A) (emphasis added). Section 1395uu, concerning payments to promote the closing or converting of under-utilized hospital facilities, provides that the Secretary, in determining the hospital's proper "transitional allowance," recognize "the outstanding portion of actual debt obligations *previously* recognized as reasonable for purposes of reimbursement." 42 U.S.C. § 1395uu(c)(1)(B) (emphasis added). We refer to these sections only to suggest that the phrase "recognized as reasonable," by itself, does not tell us whether Congress means to refer the Secretary to action already taken or to give directions on actions about to be taken. Context is all, and in this case, we believe the use of the 1984 figures for the indefinite future cautions us against a reading of the phrase that

[6] We also note that because the statute directs the HHS to *"determine"* the *"average* amount" of GME costs per FTE resident "recognized as reasonable," it seems unlikely that Congress intended for the HHS to simply look up a hospital's approved NPR for 1984 and plug it into the statutory formula. This activist language suggests that Congress must have intended for the agency to make some kind of substantive calculation on its own, which might involve as well a current assessment of the reasonableness of prior determinations.

allows no elbow room for adjustments based on prior miscalculations or errors.

Because we agree with HHS that "the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843.

B. *Reasonableness*

In its proposed regulations to implement the GME Amendments, HHS reasoned that "[b]ecause the payment methodology required by [the statute] sets future payments using the Federal FY 1984 base-period amounts as the initial starting point, we believe that it is very important that inappropriate costs not be included in the base-period amount." 53 Fed. Reg. 36,591 (1988). The agency believed that it had erroneously reimbursed hospitals for various "misclassified" and "nonallowable" costs from fiscal year 1984, *id.* at 36,591-92, and that these errors explained in part why "the range of per resident amounts for the GME base year varies from below $10,000 to over $100,000 per resident," *id.* at 36,593. As an example of a misclassified cost, the Secretary cited "physicans' compensation costs for services to the hospital that are not specifically and directly related to approved educational activities," and as an illustration of a nonallowable cost, the agency referred to "the costs of a medical school related to a hospital by common ownership or control . . . that are not directly and specifically related to patient care furnished in the hospital." *Id.* at 36,591-92. The Secretary concluded that the GME Amendments "would seem to require that we correct these discrepancies in the base period since there is no provision in the law for correcting them later." *Id.* at 36,593.

In the preamble to the regulations, the Secretary responded to a comment that concerns about past erroneous reimbursements were "unfounded," by citing "several sit-

uations . . . brought to our attention in which physicians' costs incurred for activities unrelated to GME . . . costs [were] misclassified as GME costs or excessive administrative and general service costs were allocated to the GME cost center." 54 Fed. Reg. 40,300 (1989). The Secretary based the need for reauditing on the fact that "GME costs were not given sufficient scrutiny at the time because of the many changes taking place in Medicare generally." *Id.* at 40,301. Finally, the Secretary reiterated that the 1984 GME costs should be revisited because it was "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." *Id.*

The agency's belief that Congress would resist permanently ingraining misclassified and nonallowable costs in future reimbursements to health care providers can hardly be deemed unreasonable or inconsistent with the congressional purpose of erecting a new and more accurate reimbursement methodology. *See generally Shell Oil Co. v. EPA*, 950 F.2d 741, 755 (D.C. Cir. 1991); *Ohio v. Dep't of the Interior*, 880 F.2d 432, 441 (D.C. Cir. 1989). The agency described its concerns on the rulemaking record and reasonably interpreted a statutory ambiguity to permit reauditing of 1984 GME costs in determining the "average amount recognized as reasonable" for the GME costs of each FTE resident. Moreover, recognizing that its own three year window for reassessing NPRs for 1984 had closed, the agency reasonably determined that its reauditing should only impact the base period per resident amount calculation that, by statute, would be used to compute reimbursements from 1985 onward. We do not accept, therefore, the Hospitals' argument that the agency acted unreasonably in failing to reaudit their 1984 GME costs within the three year regulatory reopening period. The three year gap between the 1986 enactment of the GME Amendments and promulgation of the agency's regulations in 1989, while unfortunate, was not an unreasonable period for developing, proposing, permitting

comment, and finalizing a regulatory framework for a complex statutory scheme.[7]

C. *Retroactivity*

As an alternative ground for its decision invalidating the agency's reauditing regulations, the district court found the regulations to be impermissibly retroactive because they allegedly lacked specific authorization in the statute. Mem. op. at 20-22. Because the 1986 GME Amendments require HHS to determine "an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985," 42 U.S.C. § 1395ww (h)(2), the statute, by its very terms, is intended to have some retroactive effect. *See Kaiser Aluminum & Chem. Corp. v. Bonjorno*, 494 U.S. 827, 837 (1990) (regarding retroactivity, "where the congressional intent is clear, it governs"). Accordingly, any regulations implementing the statute will necessarily be retroactive *insofar* as they will alter the methodology for reimbursements beginning in 1985. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988) ("*Georgetown I*") ("[C]ongressional enactments and administrative rules will not be construed to have retroactive effect unless their language requires this result."). However, that does not answer the separate question of whether reauditing the 1984 GME cost figures to determine a base period amount for computing payments from 1985 forward is improperly retroactive. We conclude that the reauditing is not an exercise in retroactive rulemaking at all, let alone an impermissible one. The reaudit carries no impact for actual 1984 reimbursements and will be used only to calculate future reimbursements. A law is retroactive if it " 'takes away or impairs vested rights acquired under existing law,

[7] We address here only the *facial* validity of HHS's reauditing regulations. Each hospital has 180 days after the calculation of its base period per resident amount to challenge the accuracy of any determination before the Board. 42 C.F.R. § 413.86(e)(1)(v).

or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past.' " *Ass'n of Accredited Cosmetology Sch. v. Alexander*, 979 F.2d 859, 864 (D.C. Cir. 1992) (quoting *Neild v. Dist. of Columbia*, 110 F.2d 246, 254 (D.C. Cir. 1940) (internal quotations omitted)). The Secretary's reauditing regulations do none of these things.

In *Association of Accredited Cosmetology Schools*, a new statute and its implementing regulations made past loan default rates an acceptable basis for terminating schools from a federally guaranteed student loan ("GSL") program, even though those rates were permissible under prior law. 979 F.2d at 859. We explained:

> Instead of undoing past eligibility, . . . the Act and the regulations merely require the Department [of Education] to look at schools' past default rates in determining future eligibility for GSL program participation. We regard this requirement as no different in substance than a lender's rule against extending credit to applicants with negative credit histories. Several cases have established that such a requirement does not operate retroactively. *See Reynolds v. United States*, 292 U.S. 443, 449 (1934)) (holding that "[a] statute is not rendered retroactive merely because the facts or requisites upon which its subsequent action depends, or some of them, are drawn from a time antecedent to the enactment"); *Neild v. District of Columbia*, 110 F.2d 246, 255 (D.C. Cir. 1940) (holding that a law is not retroactive simply because it depends on " 'antecedent facts for its operation' ") (quoting *Lewis v. Fidelity & Deposit Co.*, 292 U.S. 559, 571 (1934)). . . . We accordingly hold . . . that the Act and the regulations are not retroactive.

Id. at 865-66; *see also Campbell v. United States*, 809 F.2d 563, 571 (9th Cir. 1987).

The situation is similar here. Rather than altering 1984 reimbursements, HHS's regulations simply permit the Secretary to use reaudited versions of those past figures for the purpose of determining reimbursements in succeeding years. *Cf. Georgetown I*, 488 U.S. at 204 (regulation which changed reimbursement methodology and allowed HHS to recoup past payments under new methodology deemed impermissibly retroactive). Although in this case the GME Amendments themselves operate retroactively to alter the reimbursement methodology from July 1, 1985 onward, that contextual difference does not make the use of the reaudited 1984 figures in the new methodology retroactive in its own right. To put it another way, within the limited statutory retroactivity, the Secretary's reauditing regulations add nothing further that is retroactive: the regulations contemplate only the use of past information for subsequent decisionmaking. "In view of that conclusion, we need not consider [the Hospitals'] argument that . . . the [statute] does not speak with the requisite clarity to justify retroactive rulemaking." *Ass'n of Accredited Cosmetology Sch.*, 979 F.2d at 866.

III. CONCLUSION

For the foregoing reasons, we reverse the district court and uphold the facial validity of HHS's reauditing regulations.

So ordered.